



STATE BOARD OF OPTOMETRY
 2450 DEL PASO ROAD, SUITE 105, SACRAMENTO, CA 95834
 P (916) 575-7170 F (916) 575-7292 www.optometry.ca.gov



Case Number: _____

License Number: _____

Quarterly Report of Compliance

(Return to address shown above)

Year: _____			
Quarter			
1 st		3 rd	
2 nd		4 th	

Please Print or Type

Name:			
List name exactly as it appears on your current license/registration.			
Last	Middle I.	First	
Residence Address			Home Phone Number
Number	Street	State	
			Mobile Phone Number
Principal Place of Practice Address			Office Phone Number
Number	Street	State	
Email Address			

Probation Compliance (Standard Conditions required of ALL Probationers)

1.	Obey All Laws Since the last quarterly report, have you:	Circle One	
	1. Been arrested, charged, or convicted of any violation of Federal, State, and local laws?	Yes	No
	2. Complied with all optometry laws?	Yes	No
	3. Been disciplined by any other health-care related board or professional licensing or certification regulatory agency?	Yes	No
	Explain any YES answers and provide additional documentation if necessary		
2.	Quarterly Reports	Circle One	
	1. Do you understand that omission or falsification in any manner of any information on your quarterly reports shall constitute a violation of probation?	Yes	No
	2. Do you understand that failure to submit complete and timely reports shall constitute a violation of probation?	Yes	No

3.	Cooperate with Probation Monitoring Program Since the last quarterly report, have you:						Circle One	
	1. Complied with all requirements of probation?						Yes	No
	2. Appeared for meetings when requested?						Yes	No
	3. Claimed all certified mail, responded to all notices, and submitted reports as directed?						Yes	No
	4. Contacted your probation monitor with any questions or concerns regarding probation?						Yes	No
	Explain any NO answers							
4.	Probation Monitoring Costs Since the last quarterly report, please indicate your record of the following payments							
	First Quarter		Second Quarter		Third Quarter		Fourth Quarter	
	Month	Amount	Month	Amount	Month	Amount	Month	Amount
	January		April		July		October	
	February		May		August		November	
	March		June		September		December	
5.	Function as an Optometrist: You are required to work a minimum of 60 hours per month of probation.							
	1. Since the last quarterly report, have you had any problem meeting the minimum number of hours?						Yes	No
	2. If yes, please explain:							
	3. Since the last quarterly report, please indicate the number of hours worked per month:							
	First Quarter		Second Quarter		Third Quarter		Fourth Quarter	
	Month	Hours	Month	Hours	Month	Hours	Month	Hours
	January		April		July		October	
	February		May		August		November	
	March		June		September		December	
6.	Notice to Employer							
	1. Does the Board have the names, addresses, and telephone numbers of all employers and supervisors?						Yes	No
	2. If no, please provide the following information							
	Employer Information (Please provide any additional employers/supervisors on additional sheets if necessary)							
	Last Name		First Name		Middle I.		License #	
	Phone Number				Email Address			
	3. Have you provided your supervisor and director a copy of the decision and order and the accusation in this matter?						Yes	No
	4. Have you provided the Board with written confirmation from each employer that he/she is aware of your Discipline?						Yes	No
	If no, please have your employer submit a completed "Notice to Employer" form immediately.							
7.	Changes of Employment or Residence							
	1. Since the last quarterly report, has there been any changes of employment, location, address of record, and/or residence?						Yes	No
	2. If yes, have you submitted written notification your monitor and the Board within 14 calendar days of change?						Yes	No

	3. If NO, please explain			
8.	Cost Recovery (If applicable)	Total Amount Ordered: \$		
	1. Have you paid the total cost recovery amount in full?	Yes	No	
	2. If NO, are you participating in a Board approved payment plan?	Yes	No	
	3. If YES, have you been able to make every payment on time since your last quarterly report?	Yes	No	
	4. If NO, please explain (include dates you're able to submit payments, amounts, and documentation of why you are unable to make payments):			
9.	Take and Pass California Laws and Regulations Examination (CLRE)			
	1. Have you passed the CLRE?	Yes	Date Passed:	No
	2. If NO, have you scheduled the exam through PSI?	Yes	When:	No
	3. If NO to question 2, please explain why:			
10.	Community Service	Type (Circle one): Non-optometric or Optometric	Min. monthly hours:	
	1. Since your last quarterly report, have you been able to meet the required minimum number of hours of community service?	Yes	No	
	2. If NO, please explain:			
11.	Valid License Status			
	1. Since your last quarterly report, have you maintained a current, active, and valid license?	Yes	No	
	2. If NO, please explain:			
12.	Tolling for Out-of-State Residence or Practice			
	1. Since your last quarterly report, have you resided or practiced outside of California for over 30 calendar days?	Yes	No	
	2. If YES, please explain:			

13.	License Surrender		
	If you cease to practice due to retirement, health reasons, or are otherwise unable to satisfy any condition of probation, you may surrender your license. Do you wish to surrender your license at this time?	Yes	No
	If YES, please explain:		
14.	Violation of Probation		
	Do you acknowledge that if the Board files an Accusation or Petition to Revoke Probation, the Board shall have continuing jurisdiction and the period of probation shall be extended until the matter is final?	Yes	No
	Do you acknowledge that no petition for modification of discipline shall be considered while there is an Accusation or Petition to Revoke Probation or other discipline pending against you?	Yes	No
15.	Completion of Probation		
	Do you acknowledge that, upon successful completion of probation, your license shall be fully restored?	Yes	No
16.	Sale or Closure of an Office and/or Practice		
	1. Since your last quarterly report, have you sold or closed your practice?	Yes	No
	2. If YES, please explain how you have ensured the continuity of patient care and the transfer of patient records. In addition, state if and when you plan to refund patients for any work/services not completed or provided.		
Probation Compliance (Standard Alcohol/Drug Conditions)			
17	Abstention from Use of Controlled Substances/Alcohol		
	1. Have you abstained from alcohol and all other mood altering drugs, substances and their associated paraphernalia?	Yes	No
	2. Have you informed the Board of any prescriptions for mood altering drugs and/or other controlled substances?	Yes	No
	3. If YES to question 2, have you identified to the Board a single physician, nurse practitioner, or physician assistant who is aware of your substance abuse history and is monitoring your prescriptions?	Yes	No
	4. If YES to question 3, has the single physician, nurse practitioner, or physician assistant provided the Board with quarterly reports?	Yes	No
	5. Please explain any NO answers to questions 2-4:		
18	Biological Fluid Testing Since your last quarterly report, have you		
	1. Made daily contact with the Board's drug testing vendor to determine if you need to submit to testing?	Yes	No
	2. Submitted to all testing when selected?	Yes	No
	3. Explain any NO answers to questions 1 and 2, including when and why:		

Probation Compliance (Optional Conditions)					
__19 Participate in Group Support Meetings					
	1. Since your last quarterly report, have you attended at least one 12-step recovery meeting per week?			Yes	No
	2. If YES, have you attached the required documentation confirming such attendance?			Yes	No
	3. Explain any NO answers to questions 1 and 2:				
__20 Notice to Patients					
	1. Have you had your "Notice to Patients" approved by the Board?			Yes	No
	2. If NO, please explain:				
	3. If YES, where is this notice posted in your office?				
__21 Alcohol and Drug Treatment					
	1. Have you successfully completed a Board approved treatment program?			Yes	No
	2. Have you submitted proof of completion to the Board?			Yes	No
	3. Please explain any NO answers:				
__22 Worksite Monitor					
	1. Do you currently have a Board approved worksite monitor?			Yes	No
	Monitor's Name:	License#:	Phone#:		
	2. If YES, has the monitor been able to follow the Board approved monitoring plan since your last quarterly report?			Yes	No
	3. To the best of your knowledge, has the worksite monitor submitted the required quarterly reports to the Board?			Yes	No
	4. Explain any NO answers to questions 1-3:				
__23 Direct Supervision					
	1. Since your last quarterly report, have you been under direct supervision of an optometrist?			Yes	No
	Supervisor's Name:	License#:	Phone#:		
	2. If YES, is the optometrist able to follow the Board approved level of supervision?			Yes	No
	3. To your knowledge, has the supervising optometrist submitted the required quarterly reports to the Board?			Yes	No

	4. Explain any NO answers to questions 1-3:		
__24	Remedial Education Course	Required Areas of Education:	
	1. Have you completed or are currently enrolled in the required, Board approved, remedial education course?		Yes No
	Course Name:	Provider:	Completion Date:
	2. If NO, please explain:		
__25	Suspension	Dates of Suspension:	
	1. Have you completely ceased the practice of optometry during the period indicated above, pursuant to your Order?		Yes No
	2. If NO, please explain, including periods of practice and why:		
__26	Employment Limitations Since your last quarterly report, have you		
	1. Worked in any health care setting as a supervisor of optometrists?		Yes No
	2. Worked as a faculty member in a school of optometry or as an instructor in a CE program?		Yes No
	3. Worked in a "float" capacity?		Yes No
	4. Explain any NO answers to questions 1-3:		
__27	Psychotherapy or Counseling Program		
	1. Since your last quarterly report, have you participated in treatment by a Board approved psychotherapist or counselor?		Yes No
	Therapist/Counselor:	License#:	Phone#:
	2. To the best of your knowledge, has your psychotherapist/counselor submitted the required quarterly reports to the Board?		Yes No
	3. Please explain any NO answers to questions 1 and 2:		
__28	Mental Health Evaluation		
	1. Since your last quarterly report, have you undergone a mental health evaluation?		Yes No
	Evaluator:	License#:	Date(s) of Evaluation(s):

	2. If applicable, have you continued the evaluator's recommended restrictions, conditions, and/or treatment plan?		Yes	No
	3. To the best of your knowledge, has the evaluator submitted all required quarterly reports to the Board?		Yes	No
	4. Please explain any NO answers to questions 1-3:			
__29 Medical Health Evaluation				
	1. Since your last quarterly report, have you undergone a medical health evaluation?		Yes	No
	Physician:	License#:	Date(s) of Evaluation(s):	
	2. If applicable, have you continued the physicians recommended treatment?		Yes	No
	3. To the best of your knowledge, has the evaluator submitted all required quarterly reports to the Board?		Yes	No
	4. Please explain any NO answers to questions 1-3:			
__30 Medical Treatment				
	1. Since your last quarterly report, have you participated in treatment by a Board approved physician?		Yes	No
	Physician:	License#:	Phone#:	
	2. To the best of your knowledge, has your physician submitted the required quarterly reports to the Board?		Yes	No
	3. Please explain any NO answers to questions 1 and 2:			
__31 Restitution Amount Due: Paid To:				
	1. Have you paid the required restitution amount above, pursuant to your Order?		Yes	No
	2. If NO, explain:			
__32 Audit Required				
	1. Do you currently have a Board approved auditor?		Yes	No
	Auditor's Name:	License#:	Phone#:	
	2. If YES, has the auditor been able to follow the Board approved auditing plan since your last quarterly report?		Yes	No
	3. To the best of your knowledge, has the auditor submitted the required quarterly reports to the Board?		Yes	No
	4. Explain any NO answers to questions 1-3:			

__33	Lens Prescriptions – Maintain Records			
	1. Are you maintaining patient records of all lens prescriptions dispensed or administered by you?	Yes	No	
	2. Are these patient records available for inspection and copying by the Board or its designee?	Yes	No	
	3. Explain any NO answers to questions 1 and 2:			
__34	Restricted Practice			
	1. Since your last quarterly report, have you practiced in the areas specified in this condition of probation?	Yes	No	
	2. If YES, explain:			
__35	Restrictions as to Branch Offices			
	1. How many branch office locations do you operate?			
	2. How many branch office locations do you have proprietary interest in?			
__36	Restrictions as to Advertisement			
	1. Since your last quarterly report, have you had all advertisements of professional optometric services approved prior to public publishing/dissemination?	Yes	No	
	2. If NO, explain:			
__37	Take and Pass NBEO Exams			
	1. Have you passed the CLRE?	Yes	Date Passed:	No
	2. If NO, have you scheduled the exam through PSI?	Yes	When:	No
	3. If NO to question 2, please explain:			
__38	Continuing Education	Required area(s) of study:		
	1. Did you submit an education program/course in the areas indicated above within the required timeframe, pursuant to your Order?	Yes	No	
	2. If NO, explain:			
	3. Since your last quarterly report, have you completed any CE for this condition?	Yes	No	

	Course Name:	Course Provider:	Completion Date (attach certificate):
__39 Medical Record Keeping Course			
	1. Did you enroll in a Board approved Medical Record Keeping course within the required timeframe, pursuant to your Order?		Yes No
	2. If NO, explain:		
	3. Have you completed the Board approved Medical Record Keeping course?		Yes No
	Course Name:	Course Provider:	Completion Date (attach certificate):
Outstanding Questions, Comments, or Concerns related to your probation			
	1. Do you currently have any questions, comments, or concerns that have yet to be addressed by your probation monitor?		Yes No
	2. If YES, please explain, including when you initially brought your concerns to your probation monitor and any response, if any, that you've received.		
Declaration and Signature:			
	<p><i>I hereby submit this Quarterly Report as required by the California Department of Consumer Affairs, Board of Optometry and its order of probation thereof, and declare under penalty of perjury the laws of the State of California that I have read the foregoing report in its entirety and know its contents and that all statements made are truth in every respect, and understand that misstatements of omissions of material fact may be cause for revocation of probation.</i></p> <p>_____</p> <p style="text-align: center;">Signature</p> <p>_____</p> <p style="text-align: center;">Date</p>		

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Probationer:
License Number:
Case Number:

NOTICE TO EMPLOYER

Employer Name: _____ License Number: _____
Phone Number: _____ ext.: _____
Address: _____
Email Address: _____

Probationer's date of hire: _____

I, _____, certify that I am Dr. _____'s employer. I further certify that, on _____, said probationer provided me a copy of the Stipulated Decision, Order, and Accusation against him. I have read and I am aware of the discipline imposed by said Decision.

Further, I understand that the Board may communicate with me in regards to said probationer's work status, performance, and monitoring.

Employer's Signature

Date: _____